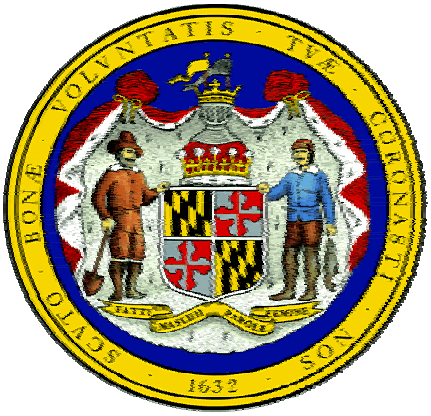
Certificate of Need Regulation of Nursing Home Services in the United States



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Preface

This study was undertaken to ascertain the status of CON regulation of nursing home services nationwide, and where possible to determine the principal effects, if any, of differing regulatory policies among states. Resource and time constraints limited the scope and depth of study. These limitations aside, the information presented may be of use to those interested in, or affected by, the development and operation of nursing homes and related health care services. It reveals distinct patterns of regulation, and related operational experiences, over the last 25 years.

The Commission appreciates the cooperation and assistance of the many state officials and long-term care organization representatives nationwide who contributed their time and knowledge. Without their generous support this study could not have been completed. Special thanks are due to the American Health Planning Association, to the current and former state certificate of need officials contacted, and to the principal authors of this report, Dean Montgomery and Thomas Piper. Their efforts and diligence helped ensure that information from all fifty states and the District of Columbia were made available. The Commission thanks each and all of them.

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I. Introduction

Long-term nursing care and related services required by the elderly are costly and are growing more so each year, as the population 65 years of age and older grows and as the intensity of care rises. Expenditures for nursing home care nationally are approaching $100 billion annually, and about 8% of total national health expenditures. With average nursing home costs now between $40,000 and $50,000 a year, and a large percentage of the elderly poor with limited economic means, the majority of these costs are necessarily born by the public. In 1997, for example, about 77% of all nursing home patients were either Medicaid (67.6%) or Medicare (9.3%) recipients.[1]

Nearly 13% of the U. S. population is now 65 years of age and older, and about 1.5% is more than 84 years of age. A small, but significant percentage of the elderly requires inpatient long-term nursing care at some point. The overall (lifetime) risk of requiring nursing home care after the age of 65 years has been estimated to be more than 40% and to be highest among those 75 to 80 years of age.[2] Over the last decade, between 4% and 5% of the elderly population has required nursing home care annually. In 1997, there were more than 1.5 million nursing home residents nationwide.

Though the elderly population has grown more rapidly than most other age cohorts in recent years, demand for nursing home care has been falling nationally, and in most states, and is not likely to increase significantly over the next decade. The rate of population growth among those age 65 years and older is likely to slow further over the next decade. This and the substitution of alternative forms of care for institutional nursing home services are likely to result in decreased use rates over the near term and keep increases in aggregate demand modest. It is unclear at this point whether use rate decreases will be of sufficient magnitude to offset increased demand over the longer term resulting from population growth.

Over the longer term demand may grow substantially, once the baby boom age cohort begins to reach first 65 years of age (2011) and then 75 (2021), and as the use of alternatives to nursing home care such as home health care and assisted living arrangements is maximized. By 2030 there may be more than 6O million persons over 65 year of age in the U.S, with perhaps as many as 3.0 to 4.0 million requiring nursing home care annually. Some longer-range projections suggest that by 2050 nearly 20% of the population, about 80 million persons, will be 65 years of age and old. The percentage of the elderly requiring inpatient

long-term nursing care is projected to stabilize at between 5% and 7% of those over age 65 years, with demand concentrated among those 75 years of age and older.[3]

Given the social and economic dimensions of the service, nursing home care has become an important component of public health and elder care policy at both the state and national levels. Governments have developed a number of policies and strategies to try to ensure that care is available and affordable. One of these is the regulation of nursing home capacity, and thereby of capital spending and of some operating costs. The principal regulatory mechanism has been, and remains, regulation of capital expenditures for new and expanded facilities under state certificate of need (CON) programs.

Long-term nursing home care was routinely included as a regulated service when state CON programs were first instituted. By 1980, 48 states and the District of Columbia regulated hospital and nursing home development. Although support for Certificate of Need regulation has eroded over the last quarter century, currently, thirty-six states and the District of Columbia have statutes authorizing CON regulation of nursing home services. Nursing home development continues to be the health facility capital expenditure most frequently regulated under state Certificate of Need programs.

II. Methods and Data

This study was designed to: (1) identify current CON regulation patterns for nursing home services nationwide; (2) document the duration and scope of regulation; (3) and, to the extent practicable, identify and assess the effects of regulatory changes over the last decade and a half on service capacity, use, operations and expenditure levels in selected states. A national survey was undertaken to collect data and information documenting historic and current CON regulation policies of each state. Customized questionnaires were sent to CON program officials in each state and the District of Columbia. The survey instrument was designed for flexible use, as a written form to be completed and returned in writing or electronically (e-mail), and in structured telephone interviews, as necessary. Unresponsive addressees were contacted by e-mail and telephone over the ensuing six weeks to assure a complete response. All fifty states and the District of Columbia provided usable data and information.

Information requested focused on the current status of CON regulation of nursing homes and related services, such as continuing care retirement community nursing home beds and assisted living beds, in each state. Data were obtained to document the dates CON coverage was initiated and terminated (if applicable), the imposition of moratoria or other market entry barriers other than

CON regulation, special or unusual licensing requirements, and the role of state Medicaid programs, if any, in controlling market entry and capacity. Appendix C contains a copy of the survey instrument.

Data and information obtained from the baseline survey were augmented with that obtained in a second survey of selected "case study" states. As with the initial basic survey, customized questionnaires were sent electronically and mailed to CON program officials and others interviewed in the states selected for study. These states were chosen to reflect a variety of regulatory policies on nursing home development between 1986 and 1996. To the extent possible, these surveys were to be structured to examine three patterns of regulation among states:

- Two states that have eliminated all market entry regulation, CON and otherwise, of nursing home development;
- Two states that have replaced CON regulation of nursing homes with a statewide moratorium on nursing home development; and
- Two states that eliminated CON regulation of nursing home capacity, but effectively replaced it with state Medicaid program market entry or capacity controls.

The baseline survey identified states in the first two categories, but none that has officially replaced CON regulation with formal Medicaid program regulation or other direct program controls. Medicaid programs play an important role, both formally and informally, in nursing home development and operations in a number of states, but none was identified as having a formally authorized controlling role.

Given the results of the baseline survey, eight states that eliminated CON regulation or replaced regulation with a formal moratorium were selected for follow-up surveys. These interviews were scheduled over the span of two weeks. Appendix C contains copies of the case study state questionnaires.

Publicly available state level nursing home development and operational data were obtained and correlated with state CON program changes to assess the possible consequences of the regulatory changes reported. Data were obtained for all states rather than just those meeting the criteria for case study follow-up surveys. This was done to try to identify as fully as possible any variation that may be related to changes in state CON regulation. A number of capacity, use and related operational effects were observed.

Unless otherwise indicated, the data presented here is for Medicare and Medicaid certified long-term nursing care facilities and services. These are the only facilities and services for which comparable national data are available over

the last two decades. Some nursing facilities do not offer skilled nursing services and hence do not participate in the Medicare program. In addition, some choose to serve only private pay patients and do not certify beds for either Medicare or Medicaid participation. These tend to be atypical programs that in the aggregate provide a relatively small proportion of total nursing home demand.

III. Nursing Home Development and Operations: Overview of National Trends

A. Advent of Medicare and Medicaid

Before the Medicare and Medicaid programs were launched, long-term care services for the elderly, particularly for the frail older person with limited economic and social support, consisted largely of a mixture of public and private old-age homes, rest homes and county welfare institutions. Most of the private facilities were founded and operated by fraternal, religious, and other charitable organizations. They and the public welfare homes provided largely custodial care, with only limited health services.

Modern nursing homes, by contrast, are clinically oriented, are largely proprietary, and have become a major component of the health care system. Many, if not most of them, were developed during a two-decade building boom surrounding the enactment of the Medicare and Medicaid programs in the mid 1960s. It is worth noting that the major increases in nursing home development and use nationally occurred by the end of that period, well before most state CON programs were established.

Effects of Medicaid and Medicare support for nursing home care can be seen in many aspects of nursing home development and operations in the decade following initiation of the programs. Capacity and demand increased in tandem, both more than doubling during the decade. The average size of facilities increased by more than 90% and the number of beds per 1,000 persons 65 years of age and older grew by more than 70%. Of course, the major change was in the source of payment for care, and the establishment of a stable, enduring base of economic support. In 1964, just before the advent of Medicare and Medicaid, public welfare accounted for nearly one-half of nursing home expenditures, with the remainder coming from other charitable sources and from private funds. By 1969, nearly 17% of payments were coming from public sources, Medicaid (13.3%) and Medicare (3.4%). Five years later, in 1974, nearly half of expenditures were by Medicaid, with public welfare outlays decreasing to about 11% and private and other charitable outlays falling to about 40 percent. Thus, the economic base of the long-term nursing care industry was transformed within less than a decade following the adoption of state Medicaid programs nationwide.

B. Maturation of Nursing Home Services

Nursing home development and operations went through a period of consolidation between the mid 1970s and the late 1980s. Following the rapid expansion of the 1960s and early 1970s, the number of certified licensed nursing homes grew relatively slowly, if steadily, over the two decades between 1978 and 1997. The 14,264 certified facilities reported in 1978 increased to 15,304 (7.3%) in 1986, and further to 17,086 (another 11.6%) in 1999 (Table A1, Appendix A). The number of licensed beds, and hence overall capacity, grew more rapidly than the number of facilities throughout the period. Certified facilities reported operating 1,307,261 beds in 1978, 1,523,027 beds in 1986 (an increase of 16.5%), and 1,843,259 beds in 1999 (an additional increase of 21.0%). The differential between the facility and the licensed bed rates of growth reflects a substantial increase in the average size of facilities operated. The average number of beds operated, which was about 75 in 1974, grew from 92 in 1978 to 100 in 1986, and to 108 in 1999 (Table 1). These changes reflect larger scales of operation and suggest improved operating efficiency and service capability generally. They occurred concomitantly with the formation of a number of large national nursing home chains.

Table 1
Medicare and Medicaid Certified Nursing Homes
U.S., 1978 - 1999

	Characteristic			Percent Change		
Year	1978	1986	1999	1978-1986	1986-1999	1978-1999
Facilities	14,244	15,304	17,086	7.3%	11.6%	19.9%
Beds	1,313,019	1,529,226	1,850,723	16.5%	21.0%	41.0%
Average Size (Beds)	92	100	108	8.7%	8.0%	17.4%

Source: Baseline Data, Tables A1, A2 and A3, Appendix A.

Demand for nursing home care kept pace with development for part of the period, but began to lag in the 1980s. The number of patients increased from about 1.1 million in 1971 to about 1.4 million in 1990, an increase of about 27%, and to a peak of about 1.5 million in 1997. Use in both 1998 and 1999 was slightly lower than demand reported in 1997 (Table A3, Appendix A).

As these data suggest, there have been substantial changes in nursing home use levels and patterns among those at high risk of requiring long-term nursing care. Although the total number of nursing home patients increased significantly between the 1950s and the mid 1990s, the rate of growth in aggregate demand decelerated over the last two decades of the period. Age-specific use rates

decreased substantially in recent years, particularly in communities and regions where alternatives to nursing home care such as home health care and assisted living facilities are readily available (Tables A15 - A16, Appendix A).

Characteristics of patients requiring nursing home care also changed noticeably. In general, nursing home patients in the 1990s were older, more debilitated, and more likely than patients a decade or more earlier to be Medicare patients and to have been admitted from hospitals rather than from home or from another nursing home. Between 1987 and 1996, the average age of elderly nursing home patients (those 65 years of age and older) rose from 83.5 to 84.6 years. The average age of nursing home residents less than 65 years of age also increased, rising from 49.3 to 50.8 years. During this period, the proportion of nursing home patients over 84 years of age increased from 49% to 56% among women and from 29% to 33% among men.[4] So, the average age of all categories of nursing home patients increased substantially over the decade.

Consistent with an older patient population, the level of disability and debility increased over the decade. In 1987, about 72% of nursing home residents in certified facilities required assistance with three or more activities of daily living (ADLs). In 1996, nearly 83% required such assistance, a 16% increase. Consistent with higher mean age levels and higher disability and acuity levels, a somewhat higher percentage of patients were admitted directly from hospitals in 1996 than a decade earlier. Average stays decreased somewhat. Average stays in freestanding facilities are now less than one year. Another notable change in recent years is the increased need for skilled nursing services and the emergence of specialty care units, e.g., Alzheimer's and dementia units, rehabilitation units and sub-acute units, to serve selected patients. There were few such specialty units in 1987. By 1996, about one nursing home in five has at least one such unit, and about 7% of licensed beds were located in specialty units.[5]

With consolidation within the industry and the associated increase in average facility size, there are now substantial economies of scale in nursing home operations. Larger facilities tend to be more efficient and more profitable than smaller facilities, and higher occupancies result in more efficient operations and higher returns than lower occupancies. Recent developments yield mixed results. The average size of facilities has continued to grow, from a median size of 100 beds in 1995 to 106 beds in 1997, increasing the opportunity to reduce marginal operating costs and to increase profits. As might be expected, given the opportunity for improved operating efficiencies and higher profits, median facility size is higher in multi-unit systems than among freestanding facilities, and higher among for-profit facilities than among public facilities.

Unlike median facility size, occupancy levels have been falling in recent years. Lower occupancy levels may reflect a number of ongoing changes in the nursing home industry. Substitution of assisted living arrangements, personal care and home health care for institutional nursing home care are likely important factors. Better and more accessible medical care, particularly more effective pharmaceuticals, help maintain a larger number and percentage of the elderly in their homes and thereby avoid institutionalization. Occupancy levels vary widely regionally and among states. Median occupancy levels are notably higher in states with stronger and more effective capacity controls (Table 4, Table A7, Appendix A).

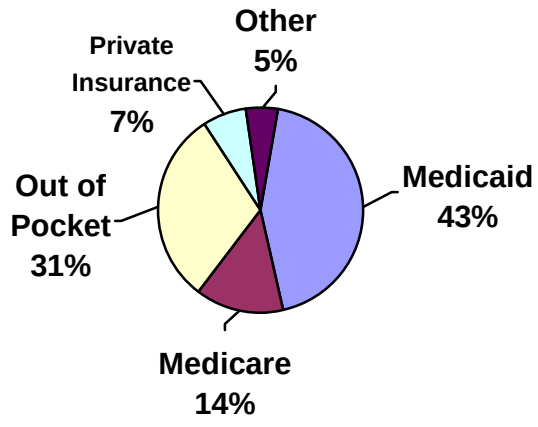
C. Evolution of Long-Term Nursing Care Financing

Historically, most people have relied on family and friends to provide long-term care and services. Although much care continues to be provided in this way, state Medicaid programs are now the primary source of payment for long-term nursing care. In 1998, approximately $100 billion was spent on nursing home care of all types nationally (Figure 1). Medicaid payments accounted for about 43% of this total. Medicare paid for an additional 14% of total outlays, largely for short-term skilled nursing services needed for rehabilitation care.

Figure 1

Nursing Home Expenditures By Payer, 1998

(Total Outlays = $100 Billion)



Source: Feder, J., et. al. "Long-Term Care in the United States: An Overview," *Health Affairs* (May/June, 2000), p. 43.

Medicare pays for skilled nursing facility care for up to 100 days following a hospital stay of three days or more. Private out-of-pocket payments represented nearly one-third (31%) of total payments. Although private insurance coverage of nursing home care has been growing in recent years, it still accounts for a relatively small percentage of total payments, only 7% in 1998. Public spending for long-term care and nursing home services varies widely among states. In 1998, the most recent year for which comparable data are available, Medicaid spending among the states for long-term care varied by more than 200%.[6]

One of the more striking developments in long-term nursing care financing and delivery patterns in recent years is the notable decrease in the proportion of patients relying on state Medicaid programs as the principal source of payment. After sustained growth for decades, the percentage of Medicaid patients, and Medicaid revenues, began to decrease in the mid 1990s (Table 7, Table A21, Appendix A). Reasons for this decrease are not well understood. Likely explanations include:

- Efforts by operators to reduce their Medicaid census in favor of more profitable private pay patients;
- Efforts by both states and operators to maximize Medicare payments, often as a substitute for Medicaid payments; and
- Efforts by payers, usually state Medicaid programs, to substitute less costly alternative forms of care, such as personal care and assisted living arrangements for nursing home care.[7]

It is noteworthy that the percentage of Medicaid patients varies widely by state and by type of ownership. Generally, nursing homes in southern states have higher Medicaid percentages than those in other regions, and proprietary facilities, particularly those located in the South, have higher Medicaid percentages than non-profit facilities.

Reimbursement cuts, more intense competition and a host of other operating difficulties notwithstanding, nursing home operations nationally remained profitable throughout the 1990s. Median operating returns grew from 3.76% in 1995 to 4.61% in 1997, an increase of 23%. Margins vary considerably by type of ownership, by facility size and among states. Proprietary facilities and facilities that are part of multi-unit systems typically enjoy higher profits than smaller, non-profit and public facilities. Investor-owned facilities are, on average, larger than nonprofit and public facilities. The larger average size appears to contribute to economies of scale and help produce higher operating returns.[8]

Average and median operating margin ranges are extremely wide, from a loss of more than 12% in Massachusetts in 1997 to a gain of more than 14% in Pennsylvania. Generally, median returns were higher in states that had higher average occupancy levels and higher average facility size. These tend to be states with CON regulation. Operating margins in Maryland were slightly higher than the national level and somewhat higher than those among other states that maintain CON regulation of nursing homes.[9]

Although operating margins through 1997 were adequate and improving in most states, changes in Medicare reimbursement payment methods and levels mandated by the Balanced Budget Act of 1997 are making positive operating returns more difficult to obtain. This is particularly true for many chain operators that built their profitability on expanding ancillary services and providing sub-acute care to larger numbers of Medicare patients. The prospective payment system called for in the Act limits payments for these services. Operators who borrowed heavily to expand to offer these services face unusually difficult problems. Several chains have been forced into bankruptcy and the capitalized value of publicly traded investor-owned chains has fallen precipitously. Some relief from the most severe strictures of the Act has been granted, and additional relief is being sought, but future operations appear problematic.

IV. State CON Regulation Patterns

States have used CON to manage the development of health care facilities and services for more than 25 years. Maryland and a few other states established programs in the late 1960s, and nearly all others adopted them by the end of the 1970s. Unlike Maryland and those states that developed CON programs between 1966 and 1973, many of the programs established after the mid 1970s were adopted in response to the National Health Planning and Resources Development Act (PL 93- 641) of 1974. This legislation tied eligibility to receive certain federal public health service grant funds to the adoption of conforming state CON programs. By 1980, all states except Louisiana and Wyoming had adopted conforming programs (Tables A1- A26, Appendix A). Maryland, one of the earlier states to establish a CON program, has regulated most hospital and nursing home services since 1968.

State regulation patterns for nursing home care are typical of those for most services covered under CON programs. The majority of states established CON programs covering nursing homes in the early 1970s. By 1974, 26 states had adopted programs. Twenty-two states and the District of Columbia adopted programs between 1975 and 1980. Two states, Louisiana and Wyoming, implemented programs after 1980. Regulations adopted in most states covered

nursing home bed development in all settings, including those developed as part of continuing care retirement communities (CCRCs) and those developed by converting acute care hospital beds to nursing home licensure and use. Few states included assisted living facilities and beds. (See Map I and Map II, Appendix B)

Overall, state nursing home CON regulatory patterns are distinctive in that:

- Fewer states have eliminated or reduced CON regulation of nursing home services than have eliminated or reduced CON regulation of any other service;
- The duration of CON regulation of these services is comparatively long, with many states beginning regulation of the service earlier and retaining it longer than for many other services;
- A surprisingly large number of states have augmented CON regulation of nursing home services with other forms of market entry or capacity management such as moratoria on development; and
- A majority of states that have formally dropped CON regulation have replaced it, at least temporarily, with equally or more stringent market entry and capacity management controls such as development moratoria and reimbursement limits (See Tables A1 - A26, Appendix A and Map I and Map II, Appendix B).

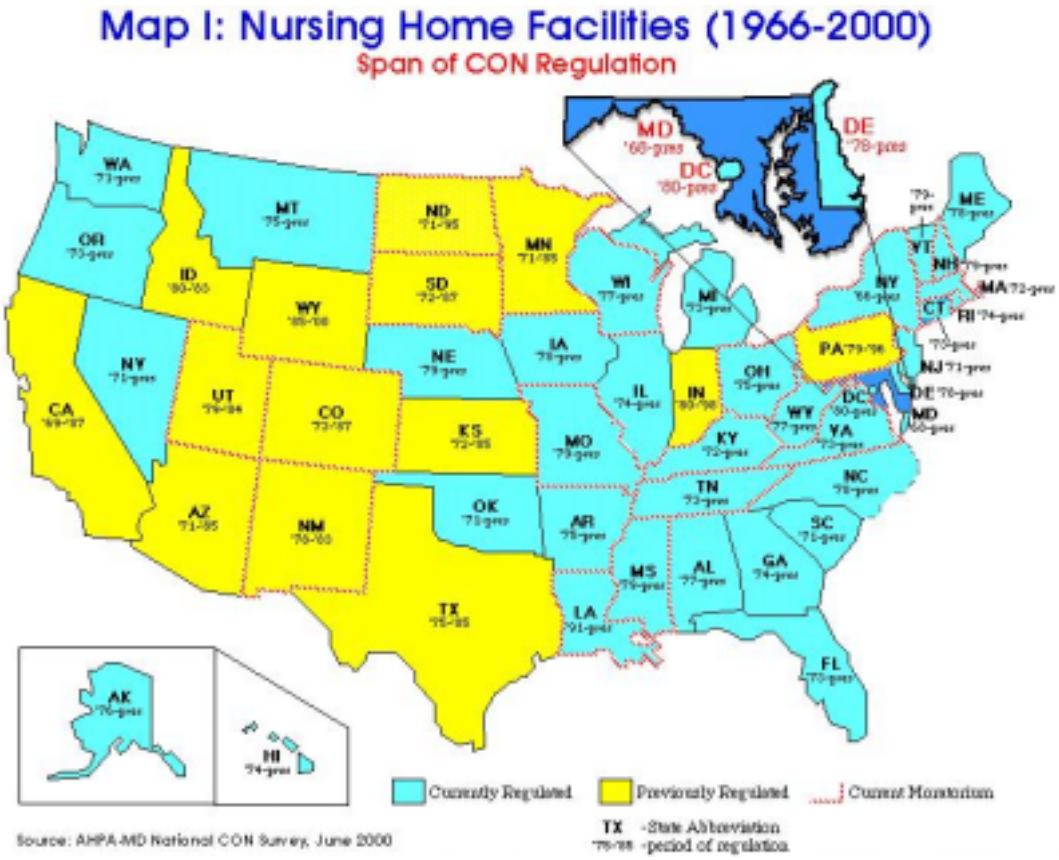
Tables A1 – A26 (Appendix A) categorize states by year 2000 regulatory status for nursing homes, delineate the duration of CON regulation for each state, and display nursing home resource, use and operations data by state.

With the exception of three western states (Idaho, New Mexico and Utah), all states regulated nursing home development and capacity for a decade or more over the last 25 years. Initially, federal health planning requirements mandated state CON coverage of nursing home services. Consequently, the CON programs adopted in the 1970s and early 1980s typically included nursing home development as a covered service.

As the enthusiasm for CON began to wane at the national level, some states began reducing the number of services regulated or eliminating the program entirely. In the 17 years between 1983 and 2000, 14 states have terminated their CON programs. Although they terminated the program, not all dropped fully regulation of nursing home development and use. A substantial number of them effectively replaced regulation with development moratoria and related market entry barriers. Some of the moratoria were subsequently dropped or relaxed, and a few were ended and then reinstated. Currently, 6 of the 14 states without CON programs have a moratorium in place. Some of the other 8 have had a

moratorium in some form in place for a number of years. South Dakota, for example, only recently dropped a moratorium on nursing home development that had been in place for about a decade following elimination of the CON program in 1988.[10] Texas, too, had a de facto moratorium on nursing home development for a decade or more following deregulation in 1985.[11]

Most of the states that terminated their CON programs, 10 of the 14, did so between 1983 and 1987, the period when Federal support for CON programs was being phased out. Four states eliminated their programs between 1995 and 2000 (Tables A1 - A26, Appendix A and Map I – Map II, Appendix B). Two of the four states eliminating CON controls in the late1990s, Indiana and Pennsylvania, imposed development moratoria on nursing home facilities.



So, though the trend over the last 15 years has clearly been toward less rather than more regulation under CON and otherwise, there has been remarkably little actual deregulation of nursing home development. The reason for this is well understood. More than two-thirds of payments for nursing home services come

from Medicaid and Medicare. The concern about excess capacity and its effects on nursing home use and costs and, hence, on public program payments has prompted policy makers to retain regulation and related planning controls in some form. [12] Other than CON regulation, the form taken has increasingly been moratoria on development.

There is a substantial body of research on the development, operations and role of nursing homes in the national health care system. Some of these studies have investigated attempts to control, and otherwise manage, nursing home capacity at the state level. One such study found the number of years a state had a CON program and imposed a moratorium on nursing home beds to be negatively correlated with both the percentage of nursing home bed growth and the ratio of beds per 1,000 persons 85 years of age and older in the state. The same study reported a positive correlation between occupancy levels and the number of years a state had CON regulation and a moratorium.[13] Others found evidence that low Medicaid payment rates, too, are effective in reducing and otherwise controlling nursing home capacity, and that variation in payment levels likely explains some of the variation in capacity among states.[14]

Bedney, Harrington and others examined the demand for long-term nursing care services and trends in nursing home development between 1978 and 1993. They collected data and contacted officials from all states and the District of Columbia to identify factors and circumstances associated with variations and trends in nursing home facility capacity changes over the 15 years studied. The investigators reached a number of conclusions worthy of note, particularly the finding that the two factors affecting the supply of nursing home beds most were state certificate of public need programs and state Medicaid reimbursement policies.[15] They did not establish the relative contributions of each factor to the supply patterns and changes observed.

They also observed that state Medicaid programs were undertaking a variety of efforts to affect both the supply of and demand for nursing home beds, and thereby reduce spending for nursing home services. The efforts reported include:

- Tightening Medicaid eligibility requirements;
- Limiting reimbursement rates (payments);
- Imposing preadmission screening for Medicaid patients; and
- Using the Medicaid home and community-based waiver programs (authorized in 1981) to expand alternatives to nursing home services, especially home health care and assisted living arrangements.

Examination of facility and bed growth rates, occupancy levels, bed-to-population ratios and the expressed opinion of state officials revealed wide variations regionally and among states, but no clear indication of appropriate or ideal

capacity levels or goals. The results showed that the ratio of nursing home beds per 1,000 persons age 65 years of age and older remained roughly stable at about 53, whereas the ratio of beds per 1,000 persons 85 years of age and older decreased substantially, from about 610 beds per 1,000 in 1978 to about 490 per 1,000 in 1993. The investigators speculated that the decrease may reflect, or be evidence of, bed ratios in high capacity (or over capacity) states regressing to the national mean, given that nearly all states with above-average ratios decreased during the period. This is possible, but not a convincing explanation in that most states with bed ratios well below the mean also had decreases (i.e., moved away from the mean). Complete occupancy level data were not available. The information that was collected showed average occupancy to be above 90% and to vary widely among states. Consistent with decreasing use rates and substantial increases in capacity, more than 80% of the state officials contacted reported that their states had either an oversupply (20 states) or and adequate supply (22 states). Only seven states reported having an under supply of nursing home beds.

As with some other researchers, the investigators found significant inverse correlations between bed-to-population ratios and average occupancy. They also found significant positive correlation between the combined effects of bed-to-population ratios and occupancy levels and the expressed opinions that the nursing home bed supply was adequate.[16]

Most of these findings are supported by the data presented in Appendix A. These data show, for example, that although there is relatively little difference between states with CON regulation and those that eliminated regulation in the rate of increase in long-term nursing care facilities overall between 1976 and 1998 (Table A1, Appendix A), the rate of increase in Medicare and Medicaid certified facilities in states that eliminated CON regulation was several times that in those states that continued CON regulation (See Table A2, Appendix A). The number of certified facilities decreased by 2.4% in states that maintained CON regulation, but increased by more than 14% in states that eliminated CON regulation and have not maintained a moratorium on development.

A somewhat different, and more interesting, picture emerges with patterns of changes in licensed beds between 1976 and 1998. The rate of growth in licensed beds was higher over the entire period in states that maintained CON than in states that eliminated CON regulation. The differential was greater for all beds (certified and uncertified) than for beds within Medicare and Medicaid certified facilities. This overall pattern shifted for certified beds during the 1990s, following the elimination of CON regulation of nursing home development in 14 states. Between 1991 and 1998, the 2.1% growth rate in certified beds in states with CON regulation was less than the 3% to 4% in states that eliminated CON regulation (Table A4, Appendix A).

The different patterns seen between facility and bed development rates by state CON regulation category is explained in part by the larger average facility size in states with CON regulation compared with states that eliminated regulation, and by the shift downward in average facility size following deregulation. In 1998, the median nursing home bed complement was 100 beds in states with CON regulation, compared with a median of 85 in states that eliminated regulation (Table A6, Appendix A). In the late 1970s, the median size of facilities in states that later eliminated CON regulation was about the same as that in states that have maintained regulation, and the median size of facilities increased throughout the period between 1976 and 1991. Between 1991 and 1998, however, the median size began to drop in states that eliminated regulation and then fell throughout the 1990s, while the average size continued to increase slowly in states that maintained regulation (Table A6, appendix A).

Occupancy levels and patterns are consistent with those observed in capacity trends and changes following the elimination of CON regulation in 14 states. Average and median occupancy decreased during the 1990s in the large majority of states regardless of CON regulation status. The median decrease in states that eliminated CON regulation and did not impose a moratorium on development (5.8%) was more than twice that of states that continued regulation (2.8%) however (Table A7, Appendix A).

Population-based capacity levels varied considerably by state CON regulation status during the 1990s. The median number of nursing home beds per 1,000 persons 65 years of age and older decreased marginally throughout the period in most states, regardless of state CON regulation status. But the median ratio in states that eliminated CON regulation, 61.5 beds per 1,000 persons 65 years of age and older in 1999, remained substantially higher than the ratio in states that continued to regulate, 49.9 beds per 1,000 (Table A8, Appendix A). Similar capacity patterns exist for the age cohort with the greatest demand for nursing home care, those 85 years of age and older. Median ratios of beds per 1,000 persons 85 years of age and older decreased substantially throughout the 1978 to 1999 period, regardless of state CON regulation status (Table A9, Appendix A). But as with the 65 years of age and older age cohort, the 535 beds per 1,000 persons 85 years of age and older in states that eliminated CON regulation and did not impose a moratorium was markedly higher than the 433 beds per 1,000 persons in states that maintained CON regulation (Table A9, Appendix A). Notably, the ratio in states that replaced CON regulation with a moratorium was much closer to the lower ratio in states that continue regulation than to the ratio in states that eliminated regulation.

Shifts in source of payment for nursing home care were fairly uniform nationally over the last decade. The percentage of patients that rely on Medicare program

payments more than doubled between 1991 and 1998, regardless of state CON regulation status. The median Medicare caseload grew from 3.9% to 8.9% between 1991 and 1998 in states that continued CON regulation (Table A10, Appendix A). The median Medicare percentage increased from 4.2% to 9.2% in states that discontinued CON regulation. Both are generally consistent with the change nationally, which grew from 4.7% to 9.4% (Table A10, Appendix A).

The increase in the percentage of patients who rely on Medicare payments was offset largely by a reduction in the proportion of private pay patients. Additionally, between 1991 and 1998, there was a small decrease in the Medicaid percentage in states that continued CON regulation and little change in states that eliminated regulation (Table A11, Appendix A). The percentage of private pay patients varies widely among states, but the median percentage decrease in private pay patients (those with private insurance and paying directly out-of-pocket) decreased by more than 10% both in states that retained CON regulation and in those that eliminated regulation (Table A12, Appendix A). As might be expected, state CON regulation status and the imposition of moratoria appear to have little affect on source of payment.

Although capacity, the number of facilities and beds, increased at a greater rate among states that eliminated CON regulation than among those that continue to regulate under CON, the number of patients served grew more rapidly in states that continue to regulate (Table A13, Appendix A). The number of nursing home residents increased by about 7.5% between 1990 and 1999 in states that retained CON regulation, compared with an increase of less than 1.0% in states that eliminated CON regulation and did not impose a moratorium. The net effect was a sharper decrease in average use and occupancy levels in nursing homes in states that dropped regulation. Most of the increased use was in non-certified beds (and thus necessarily private pay patients). Similar patterns were seen for the use of Medicare and Medicaid certified beds. Use of certified beds increased by about 3.3% between 1992 and 1997 in states that continue CON regulation compared with a 2.2% increase in states that eliminated regulation and did not impose an moratorium (Table A14, Appendix A).

Age-specific nursing home use rates vary widely from state to state, and decreased over the last decade. Nationally, the number of admissions per 1,000 persons 65 years of age and older decreased from about 45 in 1992 to about 43.0 in 1997, a 4.3% decline (Table A15, appendix A). There were similar patterns among those 85 years of age and older. The national nursing home use rate among those over 84 years of age fell from 424.7 admissions per 1,000 population in 1993 to 373.6 admissions per 1,000 in 1997, a drop of about 12% (Table A16, Appendix A).

Average and median use rates have been lower throughout the1990s among states that continue regulation, compared with those that eliminated it. The median use rate for states that retain CON regulation of nursing homes was about 39.6 admissions per 1,000 persons 65 years of age and older in 1992 compared with a median of 47.0 admissions per 1,000 population in states that dropped regulation (Table A15, appendix A). Although the median use rate decreased in states that eliminated CON regulation during the 1990s, in 1997 age-specific use rates remained substantially higher among states that eliminated regulation.

As among the entire 65 years of age and older population, median state use rates among those over 84 years of age fell about 5.8% between 1993 and 1997 in states that continue CON regulation compared with a decrease of about 2.4% among states that eliminated regulation (A16, Appendix A). The variation in median use rates in states with and without CON regulation was less pronounced for those over 84 years of age than for those in the 65 years of age and older age cohort. Nevertheless, from 1995 forward, median use rates for those over 84 years of age were lower in states that continue CON regulation than the national median and lower than the median use rate in states without CON regulation (Table A16, Appendix A).

Tables A17 – A21, Appendix A present state Medicaid expenditures for nursing home care from 1993 through 1998. The data show that:

- The total number of Medicaid recipients increased throughout the period, by about 21.4% between 1993 and 1998;
- Total Medicaid payments increased throughout the period, by about 40% between 1993 and 1998;
- The number of Medicaid patients using nursing home services fluctuated between 1993 and 1998, with net increase of about 2.2% over the period;
- Medicaid outlays for nursing home care increased throughout the period but the overall increase, 25% between 1993 and 1998, was substantially less than the increase in total Medicaid program expenditures, about 40%;
- Average expenditure per nursing home patient, too, increased throughout the period, but the net percentage increase, about 23%, was less than the increase in total program and total nursing home outlays; and
- Notably, the percentage of total Medicaid enrollees using nursing home services and the percentage of total Medicaid outlays decreased substantially over the period, 15.8% and 10.4% respectively.

These data show that, after increasing for about 25 years, Medicaid program outlays for nursing home care began to stabilize in the 1990s. The cost of providing nursing home care continues to rise, as is reflected in the continued increase in expenditure per patient throughout the period. The moderation in the

growth of total outlays is largely a function of relative stability in total demand in the late 1990s. Medicaid nursing home admissions varied somewhat from year to year, but were slightly lower in 1998 than in 1995. There is anecdotal evidence that Medicaid use has continued to decrease modestly since 1998.

Quality has been and remains one of the overriding problems in the provision of nursing home care. The fundamental nature and economics of the service, and the need to provide a wide array of health and health-related services to an overwhelmingly poor and dependent population, ensures that it will remain an abiding concern that requires constant attention. One of the underlying obstacles to assuring quality lies in the difficulty of measuring it. Tables A22 – A26, Appendix A present state level data for selected indicators commonly monitored to assess quality within and among nursing homes.

Data in these tables suggest that by most measures average quality has improved nationally throughout the 1990s. The percentage of certified nursing homes with no deficiencies (on Medicare and Medicaid inspections and surveys) increased from 10.8% in 1991 to 20.6% in 1998, a 100% increase over the decade (Table A22, Appendix A). It may be noteworthy that the median number of facilities with no deficiencies was more than twice as high in states with CON regulation compared with states that eliminated regulation. Consistent with this pattern, the average number of deficiencies reported, among nursing home with deficiencies, decreased by more than 40% nationally between 1991 and 1997 (Table A23, Appendix A). As with the state patterns for facilities with no deficiencies, facilities with deficiencies in states that retained CON regulation tended to have substantially better records (fewer deficiencies) than those in states that dropped regulation.

Reported staffing pattern problems are consistent with those for inspection deficiencies. Between 1993 and 1997, the percentage of nursing homes with insufficient staff decreased annually, with a total reduction of nearly 40% over the period (Table A24, Appendix A). Although the divergence narrowed, the median number of facilities with insufficient staff was consistently lower among states that continue CON regulation compared with those that eliminated it.

Similar patterns and trends were seen in the most recent survey data collected for FY 2000. The percentages of facilities judged to have substandard quality or to place patients and staff in immediate jeopardy were lower in states with CON regulation than in states that eliminated regulation. Conversely, percentages of facilities that were in substantial compliance with all quality measures and the percentage of facilities that were deficiency-free were considerably higher among states that retained regulation, compared with those that eliminated it (Table A25, Appendix A). It is notable that these patterns exist, even though there is little discernible difference in the average number of activities of daily living (ADL)

limitations per nursing home patient by state CON regulation status (Table A26, Appendix A).
These data combined suggest that CON regulation is not incompatible with maintaining and improving quality in nursing home services

V. Assisted Living Services

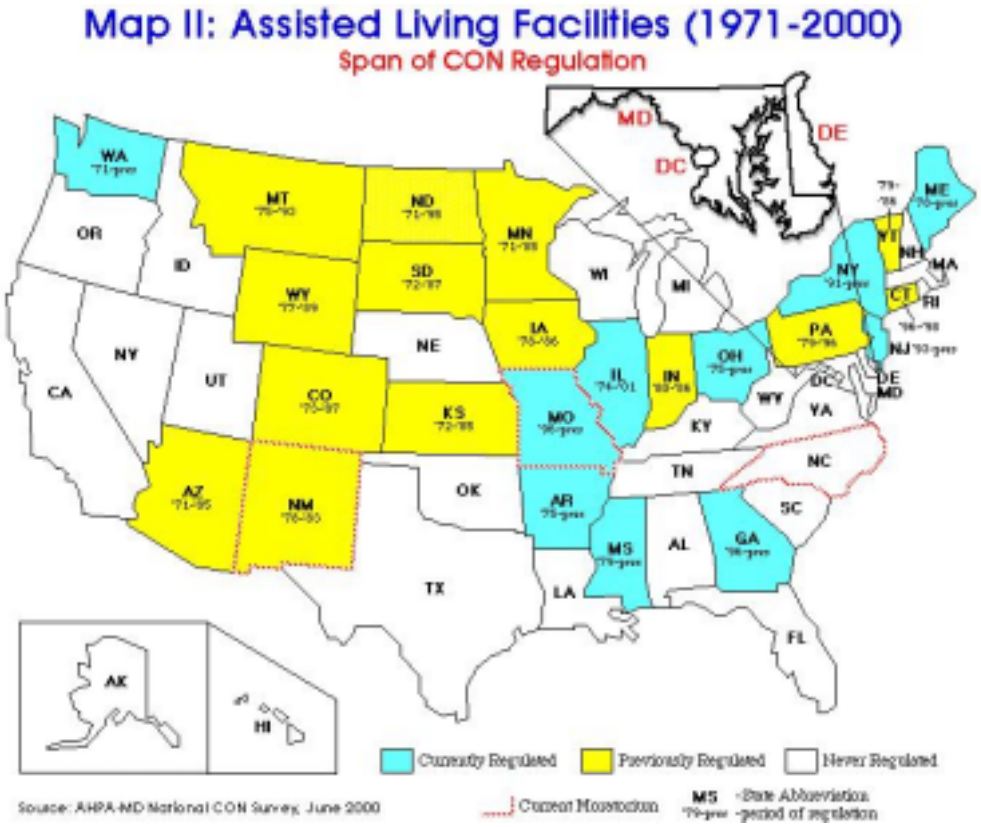
Long-term nursing care related services variously known as personal care, domiciliary care, assistance with activities of daily living, custodial care, and generically as assisted living services, have come to play an important and growing role in meeting the long-term care needs of the elderly. Care that in many respects is indistinguishable from what formerly was known as intermediate nursing home care is now provided routinely in assisted living facilities, both in those attached to, or associated with, nursing homes and in the free-standing facilities that have sprung up across the country over the last decade. This is one of the reasons age-specific nursing home use rates have decreased so sharply.

Because licensing and regulation of assisted living facilities and services varies widely from state to state, reliable comparable resource (facility and bed) and use data are not available. As shown on Map II below (and Map II, Appendix B), the majority of states (26) and the District of Columbia have never regulated assisted living facilities under their CON statues. Of the twenty-four states that regulated assisted living facilities at some point, more than half, 14 of the 24, have dropped regulation. Most stopped regulation of assisted living facilities and services, 11 of the 14 states, when they eliminated CON regulation of nursing home development. Four states eliminated regulation of assisted living facilities under CON in the 1990s.Two of them (Pennsylvania and North Dakota) did so when they stopped regulating nursing home development. The other two, Montana and Connecticut, continue to regulate nursing home services under CON.

Three states report having imposed moratoria on the development of assisted living facilities and services (Map II). Only one of them, Missouri, currently regulates assisted living facilities under its CON program. Of the other two, New Mexico dropped CON regulation of assisted living facilities in 1983 and North Carolina never applied CON regulation to assisted living facilities. Two of the states with assisted living moratoria, Missouri and New Mexico, also report moratoria on nursing home development. Missouri and North Carolina continue to regulate nursing home development. New Mexico does not.

Consistent, reliable data are not available to show the magnitude or effects of increased assisted living facility capacity nationwide. The data that are available

suggest that the number of assisted living facilities and beds now available in most states exceeds the numbers of nursing homes and nursing home beds.[17]



The availability and use of assisted living facilities appears to be reducing expressed demand at nursing homes substantially in many communities, but the magnitude of the effects have not been measured, or otherwise assessed or evaluated. It is a subject that merits careful direct study.

VI. Maryland CON Regulation Patterns

Maryland has maintained CON regulation of nursing home development and capacity since 1968. Currently, new facilities and substantial expansions of existing facilities require approval. Expansions of existing capacity by 10% or 10 beds, whichever is less, over a two-year period are exempt from planning controls. So, there can be substantial expansions of existing capacity within the existing regulatory framework. In 1999, Maryland had 255 licensed nursing homes, the overwhelming majority of which, 225 or about 88%, were certified for

both Medicaid and Medicare participation. These facilities reported operating a total of 30,674 beds and serving 25,147 patients.

As with most states, Maryland has a number of long-term care policies and initiatives that affect the demand for and use of nursing home services in ways that may not be reflected in reported aggregate state data. Among them is the extension of Medicaid coverage by means of a waiver to many of the elderly that received care at home or in assisted living facilities. Maryland began a Medicaid managed care program, HealthChoice, in 1997.[18] HealthChoice does not now cover long-term care services.

Maryland's experience with nursing home development and operations over the last 25 years compares favorably with that of the nation and most other states. As shown in Table 2, most Maryland operating indicators are positive relative to the national levels reported in the 1998-1999 period, the most recent period for which comparable data are available.

Table 2
Comparative Nursing Home Operating Profiles
United States and Maryland
1998-1999

Operational Characteristic	Maryland (1998)	United States (1999)	Maryland Indicator Positive (+) or Negative (-) Relative to US
Facilities	255	17,086	n/a
Beds	30,674	1,846,391	n/a
Average Number of Beds Per Facility	120	108	+
Average Occupancy	87.4%	80.6%	+
Median Occupancy	85.3%	88.3%	-
Population 65 Years of Age and Older (%)	11.5%	12.7%	+
Population 85 Years of Age and Older (%)	1.2%	1.5%	+
Beds Per 1,000 Persons 65 Years of Age and Older	51.8	53.7	+
Beds Per 1,000 Persons 85 Years of Age and Older	479	455.4	-
Patients Per 1,000 Persons 65 Years of Age and Older	27.8	41.4	+
Patients Per 1,000 Persons 85 Years of Age and Older	389.9	372.9	-
Medicare Certified Beds (%)	45.3%	46.4%	-
Medicaid Certified Beds (%)	92%	90.4	+
Medicare Patients (%)	10.3%	8.7%	+
Medicaid Patients (%)	63.4%	67.7%	+
Average Patient Days Per Medicare Patient	21	24	+
Average Patient Days Per Medicaid Patient	214	259	+
Proprietary Facilities (%)	57%	65.2%	n/a
Non-profit Facilities (%)	39.6%	28.3%	n/a
Average Daily Direct Care Staff Hours per Bed	2.53	2.58	-
Average Daily Direct Care Staff Hours per Patient	5.09	3.74	+

Source: Health Care Financing Administration: Online Survey, Certification and Reporting Data, March, 2000 <www.hcfa.gov.>; American Health Care Association, Research and Information Services <www.aca.org.>

Data presented in Tables A1- A26, Appendix A permit nursing home development and use patterns and trends to be compared and contrasted with those in other states and nationally. Although the total number of nursing facilities in Maryland grew more rapidly than the national average between 1978 and 1990, the rate of growth between 1990 and 1999 was roughly comparable to the rates of growth seen nationally, within states that maintain CON regulation, and below the growth rate in states that eliminated regulation before 1990 (Table A1, Appendix A). Much of this growth was among uncertified facilities. The number of certified facilities increased between 1976 and 1991 and decreased thereafter. The decrease was greater in Maryland than in most other states and the nation (Table A2, Appendix A).

The same pattern held for licensed nursing home beds, certified and uncertified. The total number of licensed beds in Maryland increased more rapidly than nationally and more rapidly than in most states between the mid 1970s and the early 1990s. Capacity peaked in 1997, and has decreased since then (Table A3, Appendix A).

Most of Maryland's nursing home bed increase between 1976 and 1997 was in uncertified beds. The growth in certified beds was substantially below the national rate and than rates in the large majority of states, regardless of CON regulation status. Most of the decrease in licensed capacity since 1997 has been in certified beds, and has been much greater than that seen nationally and in the large majority of states, regardless of CON regulation policy and status (Table A4, Appendix A). This has not resulted in an abnormally or inappropriately low complement of certified beds. The percentage of beds that are certified for Medicare and Medicaid participation in Maryland is roughly comparable to the national level (Table 2, Table A5, Appendix A).

Maryland's distinctive capacity development patterns over the last 25 years can be seen in two related operational measures: average facility size and average annual occupancy. Average facility size has been relatively high in Maryland since the 1970s. The average number of beds in Maryland nursing homes was about 103 in 1976. This was about 37% larger than the facility average nationally (Table 3, Table A6, Appendix A). By 1993, the average nursing home bed complement was 131 beds in Maryland, compared with 98 beds nationally. Average facility size in Maryland decreased to 120 beds in 1999, compared with 108 beds nationally (Table 2).

Table 3
Nursing Home Size
By State CON Regulation Status
1976 -1998

State Regulation Status	Year							Percent Change
	1976	1986	1991	1993	1995	1997	1998	1976-98
CON Regulation (N=37)	75.0	86.1	98.4	99.2	99.5	99.8	100.0	33.3
No CON Regulation No Moratoria (N=8)	74.9	75.1	89.6	86.4	86.5	86.0	85.0	13.5
No CON Regulation & Moratoria (N=6)	82.9	88.0	97.9	93.4	87.8	87.2	88.1	6.2
Maryland (Mean)	102.8	117.5	128.1	130.5	127.6	122.3	117.3	14.2
US	75.1	91.3	98.2	97.9	97.3	97.7	97.4	29.7

Source: Baseline Data in Table A6, Appendix A

Generally, larger facilities can be operated more efficiently and cost-effectively, with fixed costs spread over a larger service base. They also are more likely to have a sufficiently large patient base to offer a fuller array of needed services and a larger number of amenities.

Average occupancy levels are equally distinctive. Occupancy levels were fairly stable at well above 90 percent for much of the 1976-1990 period. They began to deteriorate in the early 1990s, and have continued slowly downward through 1998 (Table 4, Table A7, Appendix A).

Table 4
Nursing Home Occupancy Levels
By State CON Regulation Status
1992 -1998

State Regulation Status	Year							Percent Change
	1992	1993	1994	1995	1996	1997	1998	1992-98
CON Regulation (N=37)	90.4	90.7	89.6	89.8	88.1	97.8	87.9	-2.8
No CON Regulation No Moratoria (N=8)	85.0	82.8	84.1	83.8	82.7	78.5	80.1	-5.8
No CON Regulation & Moratoria (N=6)	90.5	89.6	88.5	88.8	87.3	85.2	85.6	-4.9
Maryland	94.1	93.4	92.4	92.2	91.0	88.8	87.4	-7.1
US	90.0	89.7	89.0	88.2	87.3	85.2	85.6	-4.9

Source: Baseline Data in Table A7, Appendix A; MHCC, Maryland Long Term Care Surveys, 1990-1997.

Reported occupancy appears to have rebounded somewhat in 1999 (Table 2). Nevertheless, average and median occupancies in Maryland have been far lower than the national levels and the levels in the large majority of states, regardless of CON regulation status. It decreased more rapidly during the 1990s than in the large majority of states, and nationally. The specific reasons for this have not been fully explained or documented, but it is likely that, as in a number of states, much of it results from the movement of patients from nursing homes to assisted living facilities and services.

Although its average size per facility has been comparatively high and its average occupancy levels comparatively low, Maryland's nursing home bed to elderly population ratio has not been notably high over the last 25 years. In 1978, Maryland's 51 beds per 1,000 persons 65 years of age and older was well below the national level and roughly comparable to that of other states that have continued CON regulation of nursing home services (Table 5, Table A8, Appendix A).

Table 5
Nursing Home Capacity
By State CON Regulation Status
Median Number of Beds per 1,000 Population
(Certified Beds, 1978 - 1999)

State Regulation Status	Beds per 1,000 Persons 65 Years & Older			Beds per 1,000 Persons 85 Years & Older			Percent Change 1978- 1999	
	1978	1990	1999	1978	1990	1999	65 Plus	85 Plus
CON Regulation (N=37)	52.5	54.6	49.9	601.8	520.6	433.4	-4.9	-28.0
No CON Regulation No Moratoria (N=8)	63.9	66.0	61.5	653.6	616.8	534.5	-3.8	-18.2
CON Regulation & Moratoria (N=6)	66.2	54.5	49.5	706.9	536.3	454.4	-25.2	-35.7
Maryland	51.3	50.8	51.0	635.9	554.8	504.1	-0.7	-20.7
US	55.9	55.2	50.3	621.4	536.3	451.5	-10.0	-27.3

Source: Baseline Data in Tables A8 and A9, Appendix A

Over the twenty-year period between 1978 and1999, Maryland's nursing home bed to elderly population (persons 65 years of age and older) ratio changed less than 1%. By contrast, the national rates fell by 10% and the average decrease among states with CON regulation was about 5%, making the Maryland rate roughly comparable to the national rate and to the rates of most states (Table 5).

There is a somewhat different pattern in the ratio of beds per 1,000 persons 85 years of age and older, the more rapidly growing segment of the over 65 years of

age population cohort. In 1978, Maryland's ratio was significantly higher than the national ratio, and higher than that of states with CON regulation generally (Table 6, Table A9, Appendix A). The disparity widened over the next 20 years. Although the ratio decreased by nearly 21% between 1978 and 1999, the national ratio decreased by more than 27% and the median rate among states with CON regulation by 28% (Table 5). The Maryland ratio remains relatively high, about 479 beds per 1,000 persons 85 years of age and older in 1998, compared with a national ratio of about 455 beds per 1,000 nationally in 1999 (Table 2).

It is notable that the comparatively high nursing home bed-to-population ratios, and the low average occupancy level in nursing homes, do not appear to have resulted in noticeably higher use levels. Recent age-specific nursing home admission rates have been consistently lower in Maryland than nationally and lower than among most other states, regardless of CON regulation status. In 1992, Maryland had about 39 nursing home admissions per 1,000 persons 65 years of age and older, compared with about 44 admissions per 1,000 nationally, and a median of about 40 admissions per 1,000 in all states with CON regulation (Table 6, Table A15, Appendix A).

Table 6
Nursing Home Use Rates
By State CON Regulation Status
Nursing Home Admissions per 1,000 Population
(Certified Facilities and Beds)
1992 - 1998

State Regulation Status	Admissions per 1,000 Persons 65 Years & Older 1992	1995	1998	Admissions per 1,000 Persons 85 Years & Older 1993	1995	1997	Percent Change 65 Plus (92-98)	85 Plus (93-97)
CON Regulation (N=37)	39.6	40.3	38.4	414.1	408.0	389.9	-3.0	-5.8
No CON Regulation No Moratoria (N=8)	47.0	48.4	46.7	396.3	451.6	405.9	-0.6	2.4
CON Regulation & Moratoria (N=6)	46.1	45.7	44.7	430.3	398.8	387.3	-3.1	-10.0
Maryland	38.5	36.9	27.8	429.7	403.9	389.9	-25.5	-9.3
US	43.8	42.0	39.6	420.8	409.4	390.3	-9.6	-7.3

Source: Baseline Data in Table 5 and in Tables A15 and A16, Appendix A

By 1998, the Maryland rate decreased by more than 25%, to about 28 admissions per 1,000 persons. The national rate and the rates of most states also decreased, but less sharply than in Maryland (Table 2 and Table 6). The Maryland use rate remains substantially below the national rate and the rates of most states, regardless of CON regulation status (Table 2, Table 6, Table A15, Appendix A).

Use rates among Marylanders 85 years of age and older are generally comparable with those found nationally and with median use rates in other states with CON regulation of nursing homes. Between 1993 and 1997 the Maryland rate decreased by about 9%, compared with a decrease nationally of about 7% (Table 6). The 1997 rate, about 390 admissions per 1,000 persons 85 years of age and older, was about the same as the national rate and the median rate among states with CON regulation, and was slightly lower than the median rate in states that eliminated CON regulation.

Distribution of patients by major payer category—Medicare, Medicaid and private pay—does not vary significantly in Maryland from national norms. About three-fourths of Maryland nursing home patients are Medicaid (65.1%) or Medicare (9.3%) patients, with the remainder (25.6%) private pay patients (Tables A10-A12, Appendix A). As with most states, and nationally, the percentage of patients relying on Medicare as the principal source of payment increased throughout the 1990s, with small decreases in the percentage of patients relying on Medicaid program payments and a more substantial decrease in the percentage paying with private monies. These patterns varied from state to state, but held generally nationwide. The Maryland pattern and trend do not differ significantly from that found nationally throughout the 1990s. There is some evidence of a decrease in the Medicare expenditure percentage following implementation of the Balanced Budget Act of 1997, but the full effects of these changes are yet to be reflected in reported data.

Maryland Medicaid Program nursing home use and expenditure patterns differed somewhat from national patterns over the last decade. Between 1993 and 1998, the total number of Medicaid program enrollees increased by about 26% in Maryland compared with about 21% nationally. Total Medicaid program outlays, too, grew more than the national average (Table 7).

By contrast, the number of Medicaid nursing home patients in Maryland decreased by about 33% during the period, compared with increases of about 2% nationally and about 3% among other states that continue CON regulation of nursing homes. The same pattern was evident in the percentage of Medicaid Program recipients using nursing home services. There was a substantial decrease nationally and in most states, but the decrease in Maryland was more substantial than nationally or in most other states. Conversely, total outlays for Medicaid nursing home patients, and payments per nursing home patient, increased substantially nationally and in most states, regardless of CON regulation status. The increases in Maryland were notably higher than those seen nationally and in most other states. (Tables 7 and A21, Appendix A).

Table 7
Changes in State Medicaid Expenditures for Nursing Home Care
By State CON Regulation Status
1993 -1998

State Regulation Status	Percent Change: Total Enrollees	Total Payments	Number of Nursing Home Patients	Total Nursing Home Outlays	Payment per Nursing Home Patient	Percent of Recipients Using Nursing Homes	Percent of Outlays for Nursing Home Services
CON Regulation (N=37)	18.0	37.7	3.0	26.4	22.8	-12.8	-8.2
No CON Regulation No Moratoria (N=8)	28.6	43.2	-1.9	15.3	17.5	-23.7	-19.5
No CON Regulation & Moratoria (N=6)	26.6	54.3	5.2	33.9	27.3	-16.9	-13.2
Maryland	26.2	44.7	-33.0	37.0	104.6	-46.9	-5.3
US	21.0	40.0	2.0	25.0	23.0	-15.8	-10.4

Source: Baseline Data in Table 21, Appendix A

Quality measures reported for Maryland nursing homes have been consistently better than national levels, and better than the levels reported in the large majority of states regardless of CON regulation status. Tables 8, 9, 10, and 11 below summarize these measures and contrast Maryland values with those reported nationally by state CON regulation status. The percentage of Maryland

Table 8
Percent of Facilities Without Deficiencies
By State CON Regulation Status
(Certified Facilities)
1991 -1997

State Regulation Status	Year: 1991	1992	1993	1994	1995	1996	1997	Percent Change 1991-97
CON Regulation (N=37)	8.8	11.8	8.8	13.0	15.4	22.9	23.2	163.6
No CON Regulation No Moratoria (N=8)	2.5	4.1	4.8	8.4	6.5	11.6	8.7	246.0
No CON Regulation & Moratoria (N=6)	8.9	8.9	6.7	9.6	19.2	27.6	11.4	28.1
Maryland (Mean)	24.5	29.2	31.8	21.5	30.1	34.8	36.7	49.8
US (Mean)	10.8	12.4	11.4	12.6	15.2	20.8	21.6	100.0

Source: Baseline Data in Table A22, Appendix A

nursing homes with no deficiencies was consistently higher than both the national average and the median percentage among other states with CON regulation (Table 8, and Table A22, Appendix A).

The number and percentage of deficiency-free facilities increased nationally and among all state regulation categories over the decade, particularly among those states with few deficiency-free facilities in the early 1990s. Nevertheless, in 1997 the Maryland percentage remained substantially higher than the national level and the levels reported in most other states.

Similar patterns hold for nursing facilities that did have deficiencies. Between 1991 and 1997, the average number of deficiencies reported among Maryland nursing homes was consistently lower than the national average and the averages in most other states (Table 9 and Table A23, Appendix A). The average number of deficiencies reported in Maryland facilities was consistently lower than the median number of deficiencies reported among states nationally regardless of CON regulation status (Table 9). The decrease in the average number of deficiencies over the decade was greater in Maryland than nationally and greater than in other states with CON regulation.

Consistent with the patterns of comparatively large percentages of deficiency-free facilities and comparatively low numbers of deficiencies in facilities not deficiency-free, the number and percentage of Maryland nursing homes with insufficient nursing staff has been consistently lower than nationally and lower

Table 9
Median Number of Deficiencies per Nursing Home
By State CON Regulation Status
(Certified Facilities)
1991 -1997

State Regulation Status	Year							Percent Change 1991-97
	1991	1992	1993	1994	1995	1996	1997	
CON Regulation (N=37)	7.8	6.5	6.3	6.1	5.2	4.4	3.6	-53.8
No CON Regulation No Moratoria (N=8)	12.1	10.7	8.8	7.8	6.8	6.0	5.9	-51.2
No CON Regulation & Moratoria (N=6)	8.6	7.7	6.7	5.3	4.3	3.0	5.1	-40.4
Maryland (Mean)	5.0	3.7	2.7	4.0	4.1	2.6	2.2	-56.0
US (Mean)	8.8	8.2	7.9	7.2	6.1	5.1	4.9	-44.3

Source: Baseline Data in Table A23, Appendix A

than in most other states (Table 10, Table A24, Appendix A). Generally, very few Maryland facilities have been found to have insufficient nursing personnel on staff. Even in those years when the Maryland percentage was highest, it was still only between one-fifth and one-half of the national percentage, and lower than those of most other states, regardless of CON regulation status.

Table 10
Median Percent of Facilities With Insufficient Nursing Staff
By State CON Regulation Status
(Certified Facilities)
1993 -1997

State Regulation Status	1993	1994	1995	1996	1997	Percent Change 1993-97
CON Regulation (N=37)	4.4	4.7	4.6	3.56	3.2	-27.3
No CON Regulation No Moratoria (N=8)	11.5	12.7	9.6	4.9	5.1	-55.5
No CON Regulation & Moratoria (N=6)	3.7	3.0	4.2	1.9	4.1	12.3
Maryland (Mean)	-0-	0.5	1.1	1.0	1.9	*
US (Mean)	6.2	7.0	5.7	4.2	3.8	-38.7

Source: Baseline Data in Table A24, Appendix A

*The Maryland percentage has been very low throughout the 1990s. Because the Maryland value was zero in the base year (1993), a comparable calculation was not made. All Maryland percentages were unusually low during the period.

These favorable patterns in Maryland appear to be continuing. Recently released FY 2000 survey data reveal a comparatively positive profile of nursing home operations in Maryland. Although the number and percentage of facilities judged to provide substandard care was higher than the national level and about the same as that of other states with CON regulation, all other indicators were substantially better than the national experience and than the experience in most other states, regardless of CON regulation status (Table 11, Table A25, Appendix A).

Table 11
Selected Quality Measures, US Nursing Homes
By State CON Regulation Status
(Certified Facilities)
FY 2000

	Below Expectation		Above Expectation		
State Regulation Status	Percent With Substandard Care	Percent in Immediate Jeopardy	Percent in Substantial Compliance	Percent Deficiency Free	Average Number of Deficiencies
CON Regulation (N=37)	4.2	0.9	20.5	17.8	5.4
No CON Regulation No Moratoria (N=8)	5.0	1.8	13.5	10.0	6.7
No CON Regulation & Moratoria (N=6)	2.8	0.5	23.4	18.6	4.2
Maryland (Mean)	4.2	0.0	39.8	32.0	3.1
US (Mean)	3.7	0.9	20.0	16.3	5.4

Source: Baseline Data in Table A25, Appendix A

No facilities were found to be placing patients or staff in immediate jeopardy. The percentage of facilities in substantial compliance with all operational requirements (39.8%) was roughly twice the national percentage (20%). Similarly, the percentage of facilities that were deficiency-free, though somewhat higher than in 1977, remained roughly twice the national percentage and substantially higher than the average and median levels among other states, regardless of CON regulation status. The average number of deficiencies in those facilities with deficiencies, though higher than the average reported in 1997, remained far below the national average and below the number of the large majority of other states.

VII. Perceived CON Regulation Experience: Follow-Up Questionnaire Response

No state fit the profile of replacing CON regulation with Medicaid program regulation, as called for in the original survey design. Consequently, officials in eight states divided between the other two case study categories were surveyed to obtain about their experience with regulation and deregulation of nursing home facilities and services. The eight states surveyed were Missouri, Michigan, Virginia and Wisconsin, which continue to regulate nursing home development under Certificate of Need (CON), and Colorado, Minnesota, Kansas and Texas, which have eliminated CON regulation of nursing homes (see Appendix C for questionnaires). Ultimately, 20 of the 32 agencies polled responded with usable data and comments within the timeframe of the survey.

Experiences and opinions vary greatly, but a number of commonly held views and beliefs are discernible in the collective responses. Some of the more significant are:[19]

- Most of those surveyed appear to agree that CON regulation and related planning still plays a valuable role in managing the supply of nursing home beds and related services. Many expressed the view that CON review criteria and standards need to be broadened to include and focus on manpower (nursing) problems, quality, and more competitive service delivery models.

- Most respondents report significant increases in the number of nursing homes in the early 1990s, with development tapering off in the latter half of the decade. Reported bed growth was not as rapid as facility growth, and some states were able to reduce nursing home capacity by emphasizing alternatives to inpatient care. Moratoria were reported to be relatively stable: states with a moratorium seem likely to maintain it, but it appears unlikely that additional moratoria will be imposed.

- Most of those in states with CON regulation report seeing some improvement in access to care, whereas those in unregulated states report seeing little change. Many believe access for Medicare and Medicaid patients is now more restricted than for private pay patients, largely because of more restrictive public payment policies and practices, particularly since adoption of the Balanced Budget Act of 1997.

- Many report less development in rural and inner city areas, and a corresponding shift of beds to suburban communities. Care is seen as more costly because of a shortage of key personnel, increased acuity of patients, and more complex Medicaid regulations.

- Demand for nursing home care is reported to have declined significantly in recent years because of an increased focus on less costly care options, particularly assisted living facilities and services, home care, and other elderly housing options. Nearly all emphasize a decrease in Medicaid demand, with most attributing it to program changes such as increased emphasis on less costly alternatives for what were formerly Medicaid intermediate care patients.

- Most respondents do not associate CON regulation with variations in quality because the regulatory focus is thought to be on capacity and cost containment rather than quality.

- Nursing home capital costs are reported to have increased significantly in recent years, reflecting the development of better, state-of-the-art facilities, and the development of amenities to attract private pay patients.

- Many respondents report that other controls have been added, either in support of or in lieu of CON regulation. These include stricter licensure standards, new Medicaid enrollment, screening or payment restrictions, more innovative planning controls, and the broad use of moratoria.

- A number of states have examined the value of CON regulation of nursing homes and have made a number of adjustments to the program to make it more effective. This included imposing, extending, or lifting moratoria in some. Nursing home moratoria appear to be relatively stable with repeated re-examinations in some states, but few actual changes. A number of states have considered extending CON regulation to assisted living facilities but few have done so.

- Notwithstanding the examination of CON programs in many states, no definitive studies on the value of CON regulation were reported.

- Most of those from states with CON regulation seem to want to keep it for nursing homes, and some in states without regulation would like to reinstate it. Substantial concern was expressed that discontinuance of CON regulation for nursing homes would result in accelerated facility growth, short-term profit taking, unnecessary bed development, lower utilization of capacity, and higher costs. Although few unregulated states appear likely to reinstate CON regulation, most states with regulation appear likely to maintain it.

- A number of market changes perceived as important were reported. These include the shift to innovative and more competitive models of service provision, significant shifts of less acutely ill patients to assisted living alternatives, emphasis on specialty care units (e.g., rehabilitation, ventilator dependent, Alzheimer's), lower average occupancy levels, and changes in Medicare and Medicaid reimbursement.

- Positive effects of CON regulation reported included protection of existing nursing home markets, market stability, higher occupancy levels, lower capital expenditures, industry financial stability, and better accountability.

- Negative effects reported include the belief that such regulation protects questionable and weak providers, reduces competition, protects

inefficiency, slows innovation, facilitates government interference, and is not as effective or beneficial as market forces.

VIII. Planning Criteria and Standards

A number of states report both moratoria on nursing home development and adopting other special planning criteria, standards and processes designed to improve the nursing home CON planning and review process. Many of the changes have been made to promote alternatives to institutional nursing home care, to respond to changing use rates and aggregate demand levels, and to reduce nursing home bed surpluses. Examples include nursing home "bed banks" in Wisconsin, managed brokering and relocation of surplus beds in Missouri, and a planning-based requests for applications (RFA) review process in Virginia. Attachment I contains copies of the regulations and other planning documents currently in use by these and several other states.

IX. Conclusions and Observations: General

Interest in and support for CON regulation have fluctuated over the last 30 years. Patterns and trends in the regulation of nursing home services reflect this ebb and flow. Between 1968 and 1980, 48 states and the District of Columbia adopted CON statutes that provided for the regulation of nursing home development. The other two states, Louisiana and Wyoming, later adopted programs as well. By the time these last two states adopted programs, support for regulation had begun to erode.

There have been two spates of deregulation since the mid 1980s. Ten states eliminated regulation during the 1980s, all of them between 1983 and 1987. More than half of these states immediately or subsequently imposed a moratorium on nursing home development. Six of these states maintain moratoria in 2000. Another four states dropped regulation between 1995 and 2000. Two of these states, North Dakota and Pennsylvania, imposed moratoria. Thus, 36 states and the District of Columbia now regulate nursing home development under state CON programs. The large majority of these states regulate nursing home development in all settings: freestanding facilities, units of hospitals, and components of continuing care retirement communities (CCRCs).

Notwithstanding the elimination of CON regulation in 14 states over the last decade and a half, nursing home development remains the health service most frequently regulated. Currently, only eight states report not regulating the service under CON, and not having a moratorium on nursing home development. Some of these eight states have imposed moratoria over the last 15 years. Thus, there are only about a half dozen states that have not directly controlled nursing home

development over the last decade and a half. There are distinct geographic patterns among states that have dropped regulation of nursing homes. All of the states that dropped regulation in the 1980s are located west of the Mississippi River. Most are sparsely populated Great Plains and Rocky Mountain states (Map I). Two of the states that dropped regulation in the late 1990s, Indiana and Pennsylvania, are in the eastern third of the U.S.

Because so few states have actually eliminated CON regulation, and because moratoria have been widely employed as an adjunct to CON in states that continue regulation and as a replacement for it in many states that have eliminated regulation, it is difficult to determine whether the differing operational profiles observed between states continuing CON regulation and those that have eliminated it derive from the presence (or absence) of a CON program. It is possible that, with the exception of California, the distinct geography and demography of the states that eliminated CON regulation in the 1980s, account for much of the difference seen in the 1990s between states that retain CON regulation and those that discontinued it.

Nevertheless, the differences and patterns observed appear noteworthy. They suggest that CON regulation of nursing home development may be beneficial in a number of respects. Regulation appears to be associated with slower capacity growth, higher average occupancy levels, large average facility size, lower nursing home to population (elderly at-risk population) bed ratios, and lower age-specific nursing home use rates. Collectively, these differences suggest more efficient and cost-effective use of resources in states with CON regulation.

Patterns and trends in state Medicaid expenditures for nursing home care do not appear to have differed significantly by state CON regulation status. Overall, Medicaid program enrollment and expenditures increased substantially during the 1990s. Medicaid nursing home use and outlays also increased, but at a much slower pace, and both the percentage of Medicaid program enrollees using nursing home services and the percentage of program expenditures for nursing home care decreased substantially. These patterns do not appear to have varied greatly by state CON regulation status. There is no indication that state CON regulation status is a factor in, or otherwise relates to, nursing home bed certification status or payer mix within states.

Differences in the patterns and trends in quality indicator measures reported during the 1990s suggest that CON regulation, and perhaps moratoria on development, are compatible with, if not directly conducive to, maintenance and improvement of quality. Generally, fewer deficiencies were reported in facilities in states that continued CON regulation. Similarly, facilities in those states were less likely to have insufficient staff. Favorable quality measures appear to be continuing. Survey data reported in 2000 suggest that facilities judged to have

substandard care or to place patients in immediate jeopardy were notably lower in states with CON regulation (Table 11). Consistent with this pattern, states with CON regulation appear to continue to have higher percentages of facilities that are deficiency-free, and that are in substantial compliance with all quality indicators or measures. At minimum, the data suggest that CON regulation is compatible with quality maintenance and improvement.

X. Conclusions and Observations: Maryland

Maryland, one of the first states to adopt a CON program, has regulated nursing home services since 1968. In addition to traditional nursing home beds, licensed nursing home beds in CCRCs are regulated under certain circumstances (e. g., if the number of beds desired exceeds 20% of the number of associated independent living units in facilities with more than 300 such units, or exceeds 24% of associated independent living units for facilities with 300 or fewer independent living units). Assisted living facilities and beds are licensed, but not regulated under CON.

Nursing home development and operations in Maryland over the last 25 years are distinctive and generally compare favorably with those of the nation and those of most other states. Average facility size is significantly larger than is found nationally, average occupancy levels are comparatively low, and the nursing home bed to elderly population ratio is relatively high. It is noteworthy that the comparatively high nursing home bed to population ratios, and the low average occupancy levels have not resulted in noticeably higher use levels. Age-specific nursing home admission rates have been consistently lower in Maryland than nationally and lower than in most other states regardless of state CON regulation status.

Distribution of patients by major payer category—Medicare, Medicaid and private pay—in Maryland does not vary significantly from national norms. About three-fourths of Maryland nursing home patients are Medicaid (65.1%) or Medicare (9.3%) patients, with the remainder (25.6%) private pay patients. The Maryland Medicaid Program nursing home patient caseloads and expenditures for nursing home care differed somewhat from national patterns over the last decade.

Between 1993 and 1998, the total number of Medicaid program enrollees increased by about 26% in Maryland compared with about 21% nationally. Total Medicaid program outlays, too, grew more than the national average. Conversely, the number of Medicaid nursing home patients decreased sharply in Maryland compared with a modest increase nationally and in most other states. Total outlays for Medicaid nursing home patients and expenditures per nursing home patient increased substantially nationally and in most states, regardless of

CON regulation status. The increases in Maryland were notably higher than those seen nationally and in most other states.

Quality measures reported for Maryland nursing homes have been consistently better than national levels and better than the levels reported in the large majority of states regardless of CON regulation status. The percentage of Maryland nursing homes with no deficiencies was consistently higher than both the national average and the median percentage among other states with CON regulation.

The number and percentage of deficiency-free facilities increased nationally and among all state regulation categories over the decade, particularly among states with few deficiency-free facilities in the early 1990s. Nevertheless, in 1997 the percentage of Maryland facilities that were deficiency-free remained substantially higher than the national level and the levels reported in most other states. Among nursing homes with reported deficiencies, Maryland nursing homes were found to have fewer deficiencies, on average, than facilities nationally and those in most other states.

These favorable patterns appear to be continuing. Recently released FY 2000 survey data reveal a comparatively positive profile of nursing home operations in Maryland.

Notes

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[2] Murtaugh, CM, Kemper, P, and Spillman, BC, "The Risk of Nursing Home Use In Later Life." *Medical Care* 28(10): 952-962, 1990.
[3] American Health Care Association, *The Nursing Facility Sourcebook*, 1998. Executive Summary, p. 1
[4] Rhoades, JA, Krauss NA. Nursing Home Trends, 1987 and 1996. Rockville (MD): AHCPR; 1999, *MEPS Chartbook* No. 3, p. 18.
[5] Ibid., p. 14.
[6] M. Merlis, "Financing Long-Term Care in the Twenty-first Century: The Public and Private Roles," Pub. No. 343 (New York: Commonwealth Fund) September 1999.
[7] Wiener, JM, and Stevenson, DG., "State Policy on Long-Term Care for the Elderly," *Health Affairs* May/June 1998, pp. 81-87.
[8] *The Guide to the Nursing Home Industry (1999).* HCIA, Inc., and Arthur Andersen. pp. vii-xiii.
[9] Ibid., pp. 70-71.
[10] Harrington, C., Swan, J., et. al., *1998 State Data Book on Long Term Care Program and Market Characteristics.* University of California, San Francisco, November, 1999, p. 183.
[11] Ibid. p. 191.
[12] Wiener JM, Stevenson, DG, Goldenson, SM, *Controlling the Supply of Long-Term Care Providers at the State Level.* Occasional Paper No. 22, The Urban Institute, December, 1998, pp.2-7.
[13]Harrington, C., Curtis, M., and DuNah, R., "Trends in State Regulation of the Supply of Long term Care Services," Health Care Financing Administration, San Francisco, 1994.
[14] Swan, J., Dewit, S., et. al.: "Trends in State Medicaid Reimbursement for Nursing Homes," Health Care Financing Administration, Wichita University, 1993.
[15] DuNah, R., Harrington, C., Bedney, B., Carillo, H. "Variations and Trends in State Nursing Facility Capacity: 1987-93," *Health Care Financing Review* (Fall, 1995): Vol. 17, No. 1, p. 184.
[16]Harrington, C., Curtis, M., and DuNah, R., "Trends in State Regulation of the Supply of Long term Care Services," Health Care Financing Administration, San Francisco, 1994, p. 196.
[17]Assisted living facilities are called adult care residences in Virginia. Statewide inventories in Virginia, for example, show about 1.2 registered adult care residence beds per licensed nursing home bed in the state. Adult care residence beds may be located in a number of settings, but the large majority is in freestanding settings.
[18]*The Guide to the Nursing Home Industry (1999).* HCIA, Inc., and Arthur Andersen. pp. 70-71.
[19] The detailed responses of those interviewed are included separately in Attachment I to this report.